Introduction

Where medicine meets the law, there is a fascinating and often complex interaction. One the one hand, as a doctor you are expected to work with your patient to help them to make informed choices about where and what treatment to have. Under mental health law, as a doctor, you are able to detain and forcibly treat individuals against their will. The contradiction is stark.

When is it permissible and appropriate to deprive someone of their liberty and treatment them against their will because of mental illness? A society must provide a practical response to this type of question. In England and Wales the relevant act of parliament concerned with this is the Mental Health Act 1983 (Amended 2007). The Act has to conform to the requirements of the European Human Rights Act 1998.

Guiding principles

These are a set of guidelines that should be considered when making decisions under the Act. Below are the principles that guide the Mental Health Act 1983 (Amended 2007).

Purpose principle- the Act must be used to minimize the undesirable effects of mental disorder by maximizing their safety and wellbeing (mental and physical) of patients, promoting recovery and protecting others from harm.

Least restrictive principle- people taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty.

Respect principle- people taking decisions under the Act must recognize and respect each patient including their race, religion, culture, gender, age, sexual orientation and any disability.

Participation principle- patients must be involved in their care as much as is practicable. The involvement of carers, family and friends is encouraged.

Effectiveness, efficiency and equity principle- this refers to the most appropriate use of resources to meet the needs of patients.

Principles similar to this guide most mental health law across different jurisdictions.

Statuary Criteria for detention

The statuary criteria are the legal standards that mental health professionals have to consider when assessing someone for detention under the Act. Let us consider the criteria set for detention and then look at its components in more details. These are the criteria for detention under Section 3 of the Act.

- 'The person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive treatment in hospital.
- It is necessary for the health and safety of the person or for the protection of others
- Appropriate treatment is available'

Mental Disorder

It is defined as 'any disorder or disability of the mind'. There are no exclusion criteria save for 'dependence on drugs or alcohol'. The Code of Practice for the Act (see below) states that persons cannot be considered mentally disordered simply on grounds of political, religious or cultural beliefs nor through a person's involvement in illegal, anti-social or 'immoral' behaviour. It states 'Difference is not to be confused with disorder'.

Nature or degree

This can be a difficult concept for psychiatrists! In simple terms, degree refers to the severity of the disorder i.e. how ill are they and nature refers to the previous course of that patient's disorder i.e. how long and how often have they been ill, how well have they have responded to treatment in the past etc.

Appropriate for them

The definition of mental disorder is very wide. What is key is that, in a person with mental disorder it is 'appropriate,' i.e. the mental disorder is serious enough, to detain that person in hospital. If the mental disorder is not serious enough, it might be inappropriate to treat it in hospital and treatment in the community could be considered.

Health and safety of the person and protection of others

The health and safety of the person could be issues such as self neglect, suicidal intent and impulsive behaviors that lead to a risk to the patient. The 'health of the person' includes mental as well as physical health. A person can be detained for the protection of others when a risk has been identified, for example, someone who feels paranoid to his neighbours and has voices telling him to harm them.

Appropriate treatment is available.

This ensures patients have access to effective treatment. The definition of treatment is wide and can be contentious.

Compulsory Admission to Hospital

In the England and Wales an increasing proportion of patients are being detained under the Mental Health Act. However the majority continues to be treated ‘informally’ i.e. they give their consent to be in hospital and receive treatment.

There are number of procedures usually known by the Section of the Act in which they are found (hence the verb "to section") by which patients can be detained. Application forms for the compulsory admission or treatment of a patient must be completed by nearest relative or more commonly by an Approved Mental Health Professional (usually an approved social worker). Recommendation forms must be also be completed by medical practitioner(s). When two recommendations are needed at least one doctor should be:

- "approved" by the strategic health authority as having special experience in mental disorder (usually a consultant or ST4 or above in psychiatry).
- at least one doctor (often their GP) should have previously known patient (this is not always possible).
- at least one doctor should be independent of the admitting hospital.

Patients have the right to appeal to Mental Health Review Tribunals on Sections lasting over 72 hours. Patients also have the right to appeal to the Hospital Managers, a misleading term for members of the Hospital Trust appointed for the purpose of reviewing compulsory detention. Patients detained under Section 3 of the Mental Health Act may only appeal to the Mental Health Review Tribunal on one occasion during any period of detention. There is no limit set by statute on the number of appeals which may be made to the Hospital Managers. The Managers should conduct a review when asked by the patient unless they have done so recently and there is no evidence of change.

The Department of Health publishes a "Code of Practice" outlining good practice in the application of the MHA and other aspects of mental health care.

The Sections

Section	Grounds	Requires	Duration
"2" Assessment	Mental disorder "warranting admission" **and** patient requiring detention for "own health or safety or protection of others"	1 application and 2 medical recommendations.	Up to 28 days.
"3" Treatment	See above	1 application and 2 medical recommendations.	Up to 6 months (third consecutive detention lasts up to one year).
"4" Emergency Assessment	As Section 2 but need for emergency admission before an assessment for Section 2 or 3 could be completed.	1 application and 1 medical recommendation.	Up to 72 hours if a Section 2 is being arranged.
"5(2)" Doctors' Holding Power	A patient previously admitted informally demands to leave and grounds for Section 2 apply.	Report by the responsible consultant (or nominated deputy) on an inpatient (includes general medical patients).	Up to 72 hours while further section is arranged.
"5(4)" Nurses' Holding Power	As section 5(2) but no doctor is available.	A report from qualified psychiatric nurse.	Up to 6 hours.
Community Treatment Order (CTO) (NB New in 2007)	As for Section 3. This allows for a patient who is living in the community to be recalled to hospital for treatment.	1 application and 1 medical recommendation.	Up to 6 months.

There are Sections of the Act that allow Police Officers to convey a person they suspect of being mentally ill from their own home **(Section 135)** or a public place **(Section 136)** to a place of safety, usually an A&E department or an assessment suite in a local psychiatric facility.

Patients Involved in Criminal Proceedings

The Mental Health Act allows courts to deal with mentally disordered offenders. Whilst court sections require medical recommendations, the decision as to the disposal of the case is for the court.

There are seven court sections: the two most important examples are:

Section 37: This allows a person convicted of an imprisonable offence to be detained and treated in hospital. The patient is discharged when well regardless of the length of prison sentence they may have been given if they had not been detained in hospital. **Section 41**: This restricts discharge of "dangerous" patients detained under section 37 by requiring permission from the Home Secretary.

Some criminal law also involves psychiatric reports, for example a verdict of "not guilty by reason of insanity"(person too mentally disordered to know right from wrong) or "unfit to plead" (person too mentally disordered to be subject to Court proceedings) can result in the individuals' detention under mental health legislation. The verdict of "diminished responsibility" can reduce a murder charge to one of manslaughter if certain legal criteria are met concerning the offender's state of mind at the time of the offence. If the offender is found guilty of manslaughter under the grounds of diminished responsibility, this can also lead to detention under Section 37 almost always with Section 41.

Consent to Treatment

- "Informal" patients cannot be treated for a psychiatric disorder without informed consent.
- Patients detained under Sections 4, 5(2), 135, 136 (72 hour sections) cannot be treated without informed consent.
- Patients detained under Sections 2, 3, 37 and a CTO may be given some treatments without consent under the following conditions:

General treatments

There are no conditions applied here. Nursing care, occupational therapy etc. can be given to detained patients without consent.

Medication and ECT

Consent or a second opinion (Section 58) are required. To be given ECT or prolonged medication, i.e. for more than 3 months, either the patient must give consent certified valid by the consultant (remember their wish to leave hospital is considered invalid!) or agreement to the treatment plan must be obtained from an independent doctor appointed by the CQC.

Consent to general medical treatment

The MHA applies only to treatment of mental disorder and **cannot** be used in treatment of physical conditions. Unconscious patients are treated under the auspices of the Mental Capacity Act 2005. Restraint of a potentially violent or suicidal informal patient, whether in a general medical or a psychiatric ward, would be justified on the same basis. In a detained patient the Mental Health Act has primacy.

Care Quality Commission

The Care Quality Commission is an independent non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. Part of its role is to inspect mental health facilities with regard to their compliance to the Mental Health Act with a view to protecting the rights of detained patients.

Patients' rights.

Under the MHA patients have their rights defined. Some of these are:

- Have their rights given to them at appropriate times and in an appropriate format.
- Detained patients must be informed of their right to appeal.
- The Primary Care Trusts and Social Services have a duty to provide aftercare to patients discharged from Sections 3 or 37. A Section 117 meeting should be convened with all those professionals present who will be involved in treatment after discharge.
- Detained and informal patients in psychiatric hospitals retain the right to vote.
- Mail to or from any patient may not be withheld except under special circumstances.
- All patients, formal or informal, retain the right to manage their financial affairs *etc*.
- If a patient at home or in hospital seems incapable of running their affairs these can be taken over by "the Court of Protection" especially set up for this purpose.
- The right to a independent mental health advocat

The Malaysian prospective

Malaysia has the Mental Health Act 2001 which was enacted in 2010 and which is in routine operation in Malaysian psychiatric facilities. It has much in common with the legislation in the UK. Unlike UK legislation it does not have to conform to European Human Rights law.

It sets statutory criteria for detention that are very similar to that in England and Wales i.e. a patient must be suffering from 'a mental disorder' that 'warrants admission' for 'the purpose of assessment or treatment in the interests of his own health or safety and/or with a view to the protection of others'.

Similar to the UK, the nearest relative is allowed to apply for detention but unlike the UK there is no role for another party i.e. the AMHP to apply for detention. This role lies solely with the medical profession.

Like the UK the type of Order used determines the potential length of the compulsory admission and there are mechanisms in place to make sure the detentions are regularly reviewed.

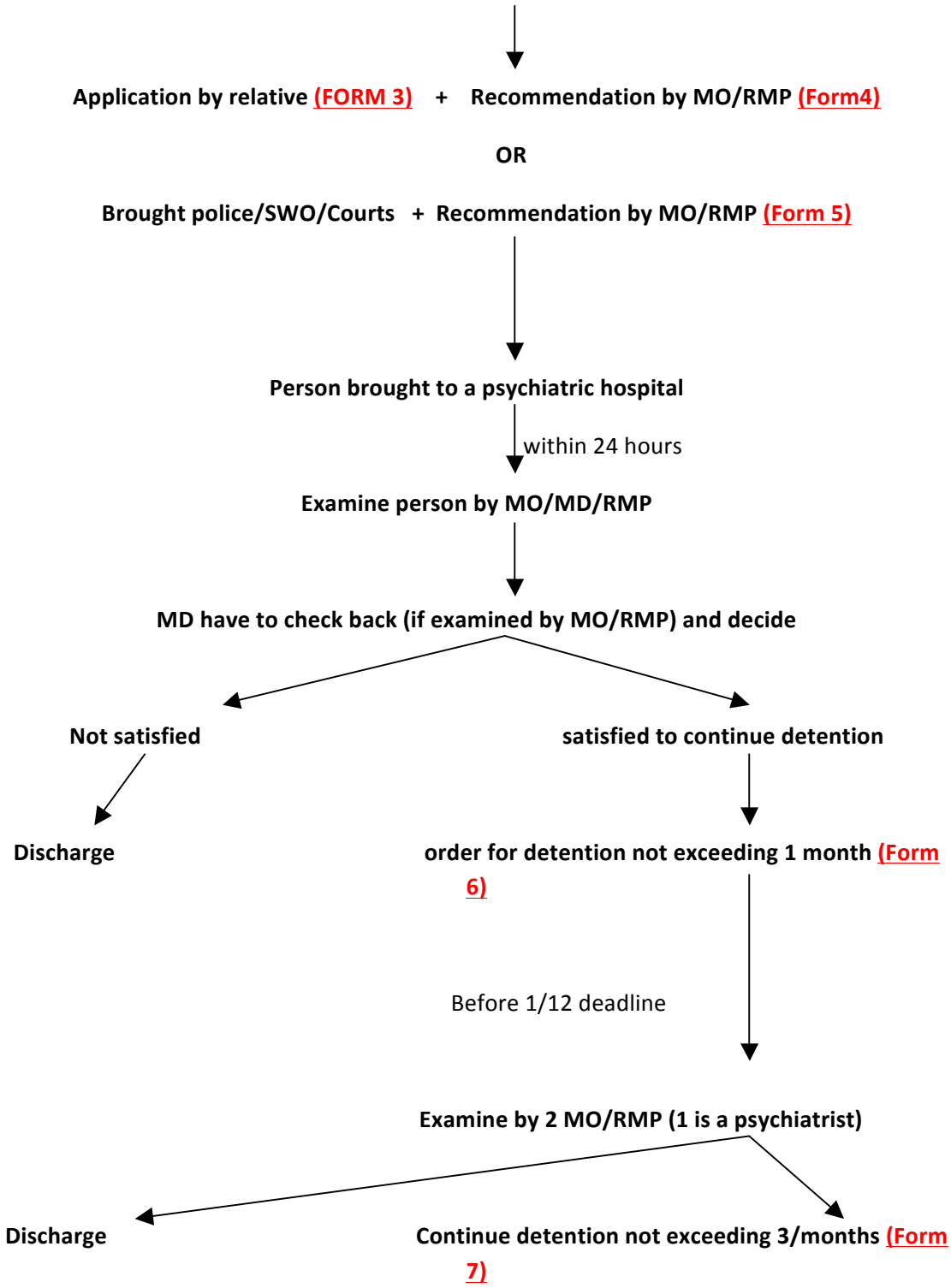
The Malaysian legislation sets out patients' rights and recommendations for standards of psychiatric facilities. It also puts in place an external agency the 'Board of Visitors' who review patients' detention, inspect facilities and look into complaints.

The Mental Health Act 2001 makes recommendations with regard to the delivery of ECT and the use of restraint or seclusion but without any specific legal criteria. The Act deals with consent pertaining to surgery, ECT or clinical trials in person who are mentally disordered. It states that 'no consent is required for other forms of conventional treatment.' For further details see section on mental capacity legislation.

It makes no provision for people with mental disorder that are facing criminal proceedings. These are dealt with in the criminal law. In the criminal law in Malaysia, a person found to be legally insane at the time of the offence and he did the act can be detained at the Rulers pleasure. Once detained at the Rulers pleasure, there is a five year minimum period after which a pardon can be applied for. This sentence is irrespective of the nature and seriousness of the offence.

ADMISSION OF INVOLUNTARY PATIENT INTO PSYCHIATRIC HOSPITAL

SUSPECTED to be Mentally Disordered



Key comparisons of mental health legislation between Malaysia and England and Wales.

	England and Wales MHA 1983 (Amended 2007)	**Malaysia MHA 2001 (Enacted 2010)**
Definition of mental disorder	Yes- broad	Yes- broad
Exclusions	Yes- dependence on drugs or alcohol in the Act. Other exclusions in Code of Practice.	Yes- immoral conduct, sexual deviancy, consumption of drugs or alcohol, particular religious or political views or antisocial personality disorder.
Who can apply	Relative, police and approved mental health professional (AMHP)	Relative, police and doctors
Informal status	Yes- no formal form required	Yes- need to sign Form 1.
Assessment sections	Yes- police, Drs and nurses holding powers- up to 72hrs Section 2- up to 28days implemented by doctors and AMHP.	Yes- relatives, doctors and police – Forms 3, 4 and 5- up to 24hrs. Then can be converted after assessment to Form 6 for up to one month.
Treatment sections	Yes- by doctors and AMHP, for up to 6 months.	Yes by doctors for up to 3 months and then by Board of Visitors for 6 months and then 1 year
Consent to treatment	Yes for medication and ECT. Surgery and medical treatment covered by MCA	Yes for ECT, surgery and clinical trials.
External review	Mental Health Review Tribunal for reviewing legality of detention, one legal person, one doctor and one other. CQC for inspection of standards and facilities	Board of Visitors covers both legality of detention and care standards. Consists of one doctor and two others, one of which must be a woman.

Scenarios

Looking at the statuary criteria and guiding principles, in the following scenarios try and make a decision about what you think should happen.

Scenario 1

A 22 year old single woman presents to A&E with an overdose. She has been declared medically fit to be discharged but the A&E doctor thinks she needs to be 'sectioned'. The patient had an abortion 6 months ago and since then has been feeling low and guilty. She has not told anyone about this. Yesterday she found out her friend was pregnant and very excited about having a baby. She took 20 tablets of her mother's antidepressant medication, which she thought would end her life. She did not particularly plan this or leave a note. After taking the tablets, she started to feel frightened and rang an ambulance.

She still feels depressed and has some biological symptoms of depression. She still feels like she wants to die but has no specific plans or suicidal intent. She just wants to go home and try and get back on with her life.

Possible outcome.

Whilst there is evidence of mental disorder (depression), it is not of a degree that would warrant detention in hospital given that the risk of suicide could probably be managed in a community setting for example with input from a Crisis team.

Scenario 2

A 25 year old musician who has a history of cannabis use and who in the last few months has become increasingly isolated, missing gigs and has been seen by his friends talking to himself. His flat mates take him to see his family doctor after he is awake all night convinced that the next door neighbours are listening to his thoughts. They had to physically restrain him several times from going around there as he says he could not cope anymore and wanted to 'sort them out.' He doesn't think there is anything wrong with him

Possible outcome

Assessment under mental health legislation in hospital is most likely appropriate in this case. There appears to be a case of a paranoid psychosis that warrants further assessment and treatment. In England and Wales, a Section 2 admission would be the most appropriate, in Malaysia initially a Form 3 completed by a relative and a Form 4

would need to be completed by the medical officer on call. Then within 24 hrs, after review by a specialist, it could be converted to a Form 6 allowing further detention or discharge.

Scenario 3

A 44 year old married lady has a history of bipolar illness. When she is unwell she presents as manic, with elevated mood, irritability and increased energy. When in this state she is prone to spending sprees and getting into arguments. These episodes are frequently precipitated by non compliance with medication. She is currently in hospital under a treatment section and is well and wanting to go home. She agrees to take her medication on discharge for a 'trial period'.

Possible outcome

Given that this is a repeated pattern, the nature of the presentation suggests that in the future non compliance and deterioration of mental health leading to risk is a real likelihood. It would be appropriate in England and Wales to consider the use of a Community Treatment Order. In Malaysia there is no legal framework to help after discharge so ongoing psycho education and close follow up would be key.

Scenario 4

A 48 year old business man is in the intensive care unit after a large overdose of paracetamol. He took this in his car in a remote spot after he had told his wife he was going away on business for a few days. There was a suicide note in the car. He was found by chance by a passer-by. Over the previous six months his business had gone bust and he had just been served a notice that his house was due to be repossessed. He is refusing any further medical treatment without which he will die. He continues to express clear suicidal intent. There are no clear symptoms of mental illness.

Possible outcome

There is no evidence of mental disorder so no grounds to detain under the mental health legislation. In England and Wales, even if he was able to be detained under the MHA, medical treatment could not be given under the Act. In Malaysia, this could be different as it makes provision for 'conventional treatment', however he would most likely be capable of refusing. In either jurisdictions, legal advice would mostly likely be sort in such a case. There are no grounds to treat under mental capacity legislation in the UK as there is no evidence of mental disorder.